

HMIS Project Update/Annual Assessment Form

HOPWA

Step 1: Basic Client Information

Please complete the following basic client information and note that all fields with an * are required fields. Universal Data Elements are required for all project participants. The response "Data Not Collected" means the question was not asked of the client and will report as missing on reports.

Basic Client Information:*

First Name: * _____ Last Name: * _____
Middle Name: _____ Suffix: _____

Step 2: Project Update/Annual Assessment

Complete the project enrollment information and please note all fields with an * are required fields. Complete additional forms for each household member to be enrolled.

Assessment Date: * _____

Case Assignment: *: _____

Covered by Health Insurance:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If Yes, Type: *

- ☐ Private - COBRA
- ☐ Private – Employer
- ☐ Private – Individual
- ☐ Medicare
- ☐ Medicaid
- ☐ State Children's Health Insurance Program (S-CHIP; not Medicaid or HIP)
- ☐ Military Insurance
- ☐ Other Public
- ☐ State Funded (HIP or HIP 2.0)
- ☐ Indian Health Service (Native American)
- ☐ Other _____

Status: *

- ☐ Active
 - ☐ Start Date: _____
 - ☐ End Date: _____

☐ No

- ☐ Applied; decision pending
- ☐ Applied; client not eligible
- ☐ Client did not apply
- ☐ Insurance type N/A for this client
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

<u>Barriers:*</u>	<u>Barrier Present?</u>	<u>Receiving Services/Treatment?</u>	<u>Condition Indefinite?</u>	<u>Documentation on File?</u>
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No

HMIS Barriers Assessment:*

If client reports "Alcohol Abuse, Drug Abuse and/or Mental Health" as present barriers, complete the following:

How confirmed:

- ☐ Unconfirmed; presumptive or self-report
- ☐ Confirmed through assessment and clinical evaluation
- ☐ Confirmed by prior evaluation or clinical records

Domestic Violence Assessment of Victim:*

Is client a victim of domestic violence:*

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected | |

Currently Fleeing:*

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected | |

If yes, when experience occurred:*

- | |
|--|
| <input type="checkbox"/> Within the past three months |
| <input type="checkbox"/> Three to six months ago (excluding 6 months exactly) |
| <input type="checkbox"/> Six months to one year ago (excluding 1 year exactly) |
| <input type="checkbox"/> One year ago or more |
| <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected |

Medical Assessment:*

Medical Assistance Type:*

- | |
|---|
| <input type="checkbox"/> Receiving public HIV/AIDS medical assistance |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |

- | |
|---|
| <input type="checkbox"/> Receiving AIDS Drug Assistance Program (ADP) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |

If No, Reason No (if applicable):

- | |
|---|
| <input type="checkbox"/> Applied; decision pending |
| <input type="checkbox"/> Applied; client not eligible |
| <input type="checkbox"/> Client Did Not Apply |
| <input type="checkbox"/> Insurance Type N/A for this Client |
| <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected |

If No, Reason No (if applicable):

- | |
|---|
| <input type="checkbox"/> Applied; decision pending |
| <input type="checkbox"/> Applied; client not eligible |
| <input type="checkbox"/> Client Did Not Apply |
| <input type="checkbox"/> Insurance Type N/A for this Client |
| <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected |

T-Cell (CD4) Count Available:*

- | | | | |
|--|--------|----------------|---|
| <input type="checkbox"/> Yes | Date:* | T-Cell Count:* | <input type="checkbox"/> Client Report |
| <input type="checkbox"/> No | | | <input type="checkbox"/> Medical Report |
| <input type="checkbox"/> Client Doesn't Know | | | <input type="checkbox"/> Other |
| <input type="checkbox"/> Client Refused | | | |
| <input type="checkbox"/> Data Not Collected | | | |

Viral Load Available:*

- | | | | |
|---|--------|--------------|---|
| <input type="checkbox"/> Available | Date:* | Viral Load:* | <input type="checkbox"/> Client Report |
| <input type="checkbox"/> Not Available | | | <input type="checkbox"/> Medical Report |
| <input type="checkbox"/> Undetectable | | | <input type="checkbox"/> Other |
| <input type="checkbox"/> Client Refused | | | |
| <input type="checkbox"/> Data Not Collected | | | |

Financial Assessment:*

Cash Income:* ☐ Yes ☐ No

- ☐ Earned Income \$ _____
- ☐ Private Disability Insurance \$ _____
- ☐ Unemployment Insurance \$ _____
- ☐ Worker's Compensation \$ _____
- ☐ Pension From Former Job (VA Included) \$ _____
- ☐ Supplemental Security Income \$ _____
- ☐ Social Security Disability Income \$ _____
- ☐ Retirement (Social Security) \$ _____
- ☐ Alimony \$ _____
- ☐ VA Service-Connected Disability \$ _____
- ☐ VA Non Service-Connected Disability \$ _____
- ☐ TANF \$ _____
- ☐ Child Support \$ _____
- ☐ Other Income \$ _____

Non Cash Benefits:* ☐ Yes ☐ No

- ☐ Food Stamps/Money for Food on Benefits Card
\$ _____
- ☐ Special Supplemental Nutrition Program (WIC)
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF Funded Services
- ☐ Section 8, Public Housing, Other Rental Asst. (PSH)
\$ _____
- ☐ Temporary Rental Assistance (RRH) \$ _____
- ☐ Other Source